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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME HEALTH CARE & HOSPICE SUPPLEMENTAL APPLICATION

Applicant Name: _____
DBA:
☐ For Profit ☐ Non-Profit ☐ Partnership ☐ Other (specify): _____
Is the Applicant's organization more than 25% owned by a private equity fund structure? ☐ Yes ☐ No
If yes, provide name of private equity firm: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
Federal Employer Tax I.D. Number: _____ # of years under present management: _____
Website address (if available): _____ Year Established: _____
Name and Phone number of person to contact for inspection: _____
Risk Management Contact: _____ Cell Phone: _____
Email: _____

If Applicant has been in business for less than 3 years the following information is required:

- ACORD Application for each line of coverage
- Currently valued losses for the time in business
- Client Contract
- Financial Statement
- Brochure and/ or Newsletter, if available
- Resume of Owner/ Principal
- Business Plan

SECTION I – APPLICANT INFORMATION

1. Current Coverages (List all coverages, i.e. GL, PL, A&M, Auto, etc.)

Coverages	Insurance Company	Limit of Liability	Occurrence or Claims Made *(if Claims Made provide retroactive date)*	Deductible	Policy Effective Dates	Annual Premium
		$		$		$
		$		$		$
		$		$		$
		$		$		$
		$		$		$

2. Type of firm (Check all that apply):
   ☐ Companion care provider ☐ Nurse registry provider ☐ Visiting nurse association
   ☐ Hospice ☐ Personal care provider ☐ Other: _____
   ☐ Infusion therapy provider ☐ Skilled Nursing provider
3. Total annual gross revenue: $_____
4. Is the Applicant licensed in all state(s) in which it is operating? ☐ Yes ☐ No
   If no, please advise if the state(s) require licensure to operate and /or perform services? ☐ Yes ☐ No
5. Is the Applicant Medicare/Medicaid certified and/or licensed? ☐ Yes ☐ No
6. Has the Applicant's license ever been suspended, revoked, voluntarily surrendered or undergone enforcement action? ☐ Yes ☐ No
   If yes, provide specifics and corrective action taken:

   _____
7. Does common ownership (over 50%) exist with any other operation? ☐ Yes ☐ No
   If yes, give names and types of operations managed and owned**: (Provide documentation)**

   _____
   If yes, is coverage desired for operations managed and owned? ☐ Yes ☐ No

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8. Does the Applicant contract with a hospital or skilled nursing facility for inpatient beds? ☐ Yes ☐ No
If yes, please explain:

9. Types of services provided.

A. Skilled Care Services			
Alzheimer's/ Dementia – Early stages	%	Obstetrical/ doula	%
Alzheimer's/ Dementia – Advanced stages	%	Occupational Therapy	%
Cardiac care	%	Palliative care	%
Case management	%	Physical Therapy	%
Chemotherapy	%	Radiation therapy	%
Clinical trials	%	Respite care	%
Dialysis	%	Speech therapy	%
Gastronomy (GT) care	%	Trach / Ventilator	%
Hospice services (Complete Section VI)	%	Other (specify): _____	%
Infusion therapy	%		

B. Non-Skilled Services			
Companion Care	%	Dietician/ Nutritionist	%
Personal Care	%	Other (specify): _____	%

C. Miscellaneous Services			
Child daycare (Complete Section X)	%	Pharmacy (Complete Section IX)	%
Clergy	%	Supplemental staffing – Non Medical (Complete Section VIII)	%
Consumer Directed Personal Assistance Program Intermediary	%	Supplemental staffing – Medical (Complete Section VIII)	%
Handyman	%	Training/ Certification	%
Meals on Wheels	%	Telehealth	%
Medical Equipment Supplier (Complete Section VII)	%	Thrift shops	%
Pet therapy	%	Wet nurse	%
Other (specify): _____	%	Other (specify): _____	%
		TOTAL % of A, B, & C (Should equal 100%)	%

10. Provide the number of clients served by age.

Age of Clients	Annual Number of Clients
0 – 5	
6 - 18	
19 - 65	
Over 65	

a. What percentage of pediatric clients are medically fragile (i.e. feeding tube, breathing tube, ventilator) _____%

11. What percentage of the overall services are live-in? _____%
***Live-in care is considered to be greater than 48 hours of continuous care provided by the same caregiver.**

12. Location(s) of Services Provided (Total must equal 100%)

Adult day care facilities	%	Owned facility	%
Assisted living facilities	%	Prisons/ Correctional Facilities	%
Hospitals	%	Private homes	%
Nursing homes	%	Schools	%
Other: _____	%	**TOTAL**	**%**

13. With respect to the coverages applied for, has any company refused, cancelled, or non-renewed coverage (Not applicable in Missouri) ☐ Yes ☐ No

14. Describe any changes in operations planned within the next year: ☐ N/A

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15. Is the Applicant accredited or a member of the following health care organizations:
    a. Community Health Accreditation Program (CHAP)? ☐ Yes ☐ No
    b. Joint Commission on Accreditation of Health Care Organizations (JCAHO)? ☐ Yes ☐ No
    c. Accreditation Commission for Health Care (ACHC)? ☐ Yes ☐ No
    d. Any other accrediting organization (please specify)?_____

16. Annual Staffing – Employees & Independent Contractors
    Total number of: Employees:_____ Independent Contactors: _____ Volunteers:_____

Staffing	Total # of Annual Hours Worked	Total # of Employees		Total # of Independent Contractors		Annual Payroll (Or 1099 Amount)	
		FT	PT	FT	PT	Employees	Independent Contractors
Case Managers							
Certified Nursing Assistants							
Companion/homemakers							
Counselors							
Dentists*							
Licensed Social Workers							
LPN's							
Medical Directors *(Admin Only)*							
Nurse Practitioners							
Nutritionists							
Occupational Therapists							
Opticians*							
Optometrists/Ophthalmologist							
Paramedic EMTs							
Pediatricians*							
Personal Care Attendants							
Pharmacists							
Physicians*							
Physicians Assistants							
Physicians Hospice*							
Physical Therapists*							
Psychiatrists*							
Psychologists							
Resident Managers							
RN's							
Social Workers							
Speech Therapists							
*Other (describe):_____							
*Other (describe):_____							

F/T = Full Time – over 20 hours per week / P/T = Part Time – up to 20 hours per week

***If the Applicant is requesting primary medical professional coverage for any of above noted Physicians, Psychiatrists, Dentists or Opticians, the Applicant must submit a completed and signed Medical Professional application. Coverage for such professional is subject to Underwriting review and approval.**

***Complete the following chart if Vicarious medical professional coverage is desired for professional services rendered on the Applicant's behalf by the above noted employed or volunteer Physicians, Psychiatrists, Dentists or Opticians who carry their own primary medical professional insurance:**

Professional's Name	Medical Specialty	Medical License #	Primary Ins. Carrier	Primary Limits

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SECTION II - HIRING / SCREENING

1. Check all methods used in the hiring/ screening process:

Hiring/ Screening Processes	Employee	Contractors	Volunteers
Drug & Alcohol testing – At time of Hire	☐	☐	☐
Drug & Alcohol testing - Randomly	☐	☐	☐
Criminal background checks – Federal	☐	☐	☐
Criminal background checks – State	☐	☐	☐
Reference checks - Written	☐	☐	☐
Reference checks - Verbal	☐	☐	☐
Personal interview	☐	☐	☐
Sexual abuse registry	☐	☐	☐
Validate work history	☐	☐	☐
Validate education	☐	☐	☐
Verify current certification/ Professional license	☐	☐	☐
Validate driver's license	☐	☐	☐
Validate personal auto insurance and limits (If operating owned vehicle during company Hours)	☐	☐	☐

2. What is the average staff turnover rate:_____%
3. Are job descriptions provided for all professional and non-professional employees? ☐ Yes ☐ No
4. Does the Applicant question prospective employees and/or independent contractors about ever having their license revoked or suspended, any disciplinary action taking against them or being a defendant in professional litigation? ☐ Yes ☐ No
   If no, please explain what verification procedures are in place:

   _____
5. Are independent contractors required to carry their own individual professional liability coverage? ☐ Yes ☐ No
   Limits of Liability: $_____
6. Describe any additional pre-employment screening and assessments procedures?

   _____

SECTION III - RISK MANAGEMENT – QUALITY CONTROL

1. Is the overall responsibility for Risk Management assigned to one individual in your organization? ☐ Yes ☐ No
   If no, how are the risk management functions monitored?

   _____
2. Describe what formal documented training is in place:

   _____
3. What is the average training provided to newly hired staff:
   ☐ >5 Hours ☐ 1 – 5 Hours ☐ No training is provided
4. What is the average ongoing training provided to their staff:
   ☐ >8 Hours ☐ 1 – 7 Hours ☐ No ongoing training is provided
5. Does the Applicant provide training to all employees on how to properly transfer clients? ☐ Yes ☐ No
6. Does the Applicant have formal HIPAA compliance procedures in place? ☐ Yes ☐ No
7. Does the Applicant have a formal incident report procedure in place? ☐ Yes ☐ No

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8. Does the Applicant have developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures:
   a. Copy of literature given to clients explaining services and fees? ☐ Yes ☐ No
   b. Complete treatment plan prescribed by the physician, including follow up plans? ☐ Yes ☐ No
   c. Medications and dosage, including documentation of administering medications? ☐ Yes ☐ No
   d. Complete medical records maintained on all patients? ☐ Yes ☐ No
      If yes, are records kept on file (hardcopy or electronic) for a minimum of 6 years? ☐ Yes ☐ No
   e. Standard client contracts and "informed consent" documents obtained and placed in the patient's medical record? ☐ Yes ☐ No
      If yes, please attach a copy of standard client contract.
   f. Documentation of all homecare training? ☐ Yes ☐ No
   g. Meticulous documentation of all patient care and home visits? ☐ Yes ☐ No
   h. Changes in the condition of a patient or incidents involving the patient documented in the records and reported to the family and physician? ☐ Yes ☐ No
   i. Termination of services and discharge of criteria? ☐ Yes ☐ No
9. Does the Applicant have current contracts with pharmacies, durable medical equipment suppliers, hospitals, nursing home and/or assisted living homes in place? ☐ Yes ☐ No
   If yes, is there a review process requiring the following elements: **(**Please attach copy of all agreements.**)**

Hold harmless and indemnification clauses favorable to the applicant?	☐ Yes	☐ No	Terms and renewal conditions clearly outlined?	☐ Yes	☐ No
Insurance requirements?	☐ Yes	☐ No	Termination clause?	☐ Yes	☐ No
Confidentially clause?	☐ Yes	☐ No	Defined roles and responsibility?	☐ Yes	☐ No

10. Does the Applicant require employees and independent contractors to complete daily work reports? ☐ Yes ☐ No
11. Does the Applicant conduct patient/ client surveys? ☐ Yes ☐ No
    If yes, are the results to improve day-to-day operations? ☐ Yes ☐ No

SECTION IV – ABUSE AND MOLESTATION

1. Does the Applicant's organization have a written "zero tolerance" sexual and physical abuse molestation policy? ☐ Yes ☐ No
   If yes:
   a. Does the Applicant's written policy include: **(Please provide a copy)**

Definition of sexual and physical abuse/molestation?	☐ Yes	☐ No	Investigation procedures?	☐ Yes	☐ No
			Disciplinary procedures?	☐ Yes	☐ No
Incident reporting procedures	☐ Yes	☐ No	Retaliation warning?	☐ Yes	☐ No

   b. Is the policy consistently enforced, requiring annual review by each employee and/or volunteer, mandating individual signoff that they/ them has read the policy, has received appropriate training and agrees to adhere to the policy? ☐ Yes ☐ No
   c. Have procedures been established to monitor the implementation of the program? ☐ Yes ☐ No
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? ☐ Yes ☐ No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if they have an incident of abuse? ☐ Yes ☐ No
4. Are there written procedures that monitors staff in day-to-day relationships with clients, both on and off premises? ☐ Yes ☐ No
5. Is there formal staff training on sexual abuse, including how to recognize the signs? ☐ Yes ☐ No
6. Is there more than one person responsible for the welfare of any single live-in patient? ☐ N/A ☐ Yes ☐ No
7. Will any independent contractors have access to children or perform operations where they will be physically touching another person? ☐ Yes ☐ No
   If yes, please explain:

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8. Have any incidents resulted in an allegation of sexual or physical abuse? ☐ Yes ☐ No
If yes, please explain:

SECTION V - AUTOMOBILE

1. Are there any company-owned vehicles? ☐ Yes ☐ No
****Please note that we will not write the non-owned auto without the scheduled vehicles.**
If yes:
   a. Does the Applicant allow personal use of a company-owned vehicle? ☐ Yes ☐ No
   b. Is there a formal, written Fleet Safety Program in place? ☐ Yes ☐ No
   c. Are family members allowed to use the company owned vehicles? ☐ Yes ☐ No
   d. Does the Applicant allow any newly hired drivers to operate vehicles without going through a company specific documented driving training? ☐ Yes ☐ No
2. Does the Applicant contract with an ambulance or livery service to transport clients? ☐ Yes ☐ No
(If yes, please provide a copy of the contract)
3. Does the Applicant make sure travel logs are kept for all drivers? ☐ Yes ☐ No
4. How often does the Applicant check MVR reports? ☐ Never ☐ At time of hire only ☐ Annually ☐ Randomly
5. Does the Applicant have a formal driving policy in place with MVR standards? ☐ Yes ☐ No
If yes:
   a. Is driving policy communicated in writing to all employees? ☐ Yes ☐ No
   b. Is a signed acknowledgement form kept on file? ☐ Yes ☐ No
   If yes, please provide a copy of signed acknowledgement.
   c. Do driving standards include the following:
      i. No major violations including DUI, racing, hit and run, speeding in excess of 20 mph over posted speed limit, manslaughter? ☐ Yes ☐ No
      ii. No more than 2 moving violations within past 3 years? ☐ Yes ☐ No
      iii. No more than 1 at fault accident within past 3 years? ☐ Yes ☐ No
6. Are all drivers at least twenty-one (21) years of age? ☐ Yes ☐ No
7. Are all drivers trained on wheelchair securement protocols & procedures? ☐ Yes ☐ No
8. Number of Applicant's staff who use their personal vehicles within the scope of business:
Employees: _____ Volunteers: _____ Independent Contractors: _____
   a. Total annual miles driven by staff: _____
9. Does the Applicant allow staff to transport clients? ☐ Yes ☐ No
If yes:
   a. How often is transportation provided? _____
   b. How many of the Applicant's staff aged between twenty-one (21) to twenty-five (25) transport clients? _____
   c. Are any clients non-ambulatory? ☐ Yes ☐ No
10. Does the Applicant obtain certificates of insurance or a copy of the declarations page from the caregiver's personal insurer? ☐ Yes ☐ No
If yes, who maintains these records? _____
11. Does the Applicant confirm all drivers personal auto policies do not exclude claims arising out of the course of driving if part of their profession? ☐ Yes ☐ No
12. Does the Applicant require caregivers to carry personal auto insurance with limits of at least $100,000? ☐ Yes ☐ No
13. Does the Applicant require independent contractors to list the Applicant as an additional insured? ☐ Yes ☐ No
14. Does the Applicant allow their caregivers to operate client vehicles? ☐ Yes ☐ No
If yes:
   a. How does the Applicant verify patient and/or client owned automobile liability coverage is in force? _____
   b. Does the Applicant require evidence of regular preventative maintenance? ☐ Yes ☐ No

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SECTION VI - HOSPICE ☐ N/A

1. Describe the Applicant's Hospice Model (Please check all that apply):

Freestanding:	A hospice inpatient facility that is administratively and physically freestanding. This type of hospice operates a home care program for the inpatient.	☐
Hospital-Based:	A hospice administratively or physically linked to a hospital. This type of hospice operates a home care program and may also operate an inpatient unit.	☐
Nursing Home Based:	A hospice administratively or physically linked to a nursing home or long-term care facility. This type of hospice operates a home care program and an inpatient unit.	☐
Community-Based:	A hospice home care program that operates under an autonomous administration. This type of hospice may be affiliated with an inpatient unit.	☐
Home Health Agency Based:	A hospice administratively or physically linked to a Hospital-Based or Home-Health Agency. This type of hospice may contract for inpatient services.	☐

2. Describe the Applicant's Hospice "Type" (please check all that apply):

Routine Home Care	As long as the patient's symptoms are under control, the hospice team supports the caregivers in providing this level of care in the home setting, whether that is a private residence, assisted living or nursing home. # of patients for type of service (12 months' time): _____ # of visits for type of service (12 months' time): _____	☐
Crisis Care	In the event of a medical or psychosocial crisis, 24-hour care can be provided in the home for brief periods. # of patients for type of service (12 months' time): _____ # of visits for type of service (12 months' time): _____	☐
Inpatient Respite Care	Caregivers occasionally need to take short breaks to maintain their own health. In this instance, the patient can be transferred to a short-term (up to five days) care unit while the caregiver takes a break. Respite care is provided in a nursing home setting. # of patients for type of service (12 months' time): _____ # of visits for type of service (12 months' time): _____	☐
General Inpatient Care	When symptoms can't be controlled in a home setting, this level of care may be provided in many hospitals or the patient can be moved to an Inpatient Center for a short-term stay until pain and symptoms are under control. This level of care is also offered in select nursing homes. Patients residing in such nursing homes may be moved to an inpatient bed within the same facility. In all other nursing homes, patients may be moved to an Inpatient Center or to a nearby hospital. # of patients for type of service (12 months' time): _____ # of visits for type of service (12 months' time): _____	☐

3. Please provide the percentage of the age of Hospice clients served:

Client	Percentage	Client	Percentage
Children/ Teenagers (1-17)	%	Adults (22-64)	%
Young Adults (18-21)	%	Geriatric (over 65)	%

4. Are medications kept in a locked area to prevent tampering? ☐ Yes ☐ No
5. Describe the organization's policy for disposal of controlled substances:

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SECTION VII – MEDICAL SUPPLIES ☐ N/A

1. Does the Applicant manufacture any products? ☐ Yes ☐ No
   If yes, please describe:

2. Does the Applicant provide any durable medical equipment to clients? ☐ Yes ☐ No
   If yes, please describe:

3. Does the Applicant sell any medical supplies or equipment? ☐ Yes ☐ No
   If yes, please describe:

   Total annual sales: $_____
4. Does the Applicant rent or lease any medical supplies or equipment to others? ☐ Yes ☐ No
   Total rental or leasing sales: $_____
5. Does the Applicant repair or perform maintenance on any medical supplies or equipment? ☐ Yes ☐ No
6. Is the Applicant named as an Additional Insured – Vendor on the manufacturer or supplier's policy for any products? ☐ Yes ☐ No
7. Does the Applicant obtain certificates of insurance from their product suppliers? ☐ Yes ☐ No
8. Has the Applicant ever distributed or directly imported products from a foreign manufacturer? ☐ Yes ☐ No
9. Does the Applicant modify any product in any way from its intended use? ☐ Yes ☐ No
   If yes, please explain:

10. Does the Applicant repackage or re-label any items obtained from suppliers? ☐ Yes ☐ No
11. Do manufacturer's labels remain on the equipment? ☐ Yes ☐ No
12. Are serial numbers of the finished product shown on invoices and complete records of inventory kept? ☐ Yes ☐ No
13. Products Offered **(Percentages must equal 100%)**

Product/ Service		Product/ Service	
Apnea monitors	%	Parental Therapy	%
Apnea monitors – infant	%	Pharmacy sales	%
Auto conversions / modifications	%	Photo therapy equipment - infants	%
Bed, commodes	%	Scooters	%
Blood cleansing or recirculation equipment	%	Safety bar/ Grab bar installation	%
Chemotherapy	%	Safety bar/ Grab bar sales	%
CPAP/ BIBPAP	%	Sleep apnea studies	%
CPM	%	Stair lift – installation	%
Diabetic shoes	%	Stair lift – sales	%
Enteral Therapy	%	Ten units	%
Infant beds or cribs	%	Ventilators	%
Liquid oxygen	%	Does the Applicant instruct on the use of ventilators? ☐ Yes ☐ No	
Medical gas piping	%		
Nebulizers	%	Walkers, crutches, canes	%
Orthotics & prosthetic sales or fitting	%	Wheel chair – motorized	%
Oxygen concentrators	%	Wheel chair – manual	%
Oxygen cylinders	%	Other:_____	%
Oxygen regulators and values	%	Other:_____	%
		ABOVE MUST TOTAL 100%:	%

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SECTION VIII- SUPPLEMENTAL STAFFING ☐ N/A

1. If the Applicant provides any supplemental staffing services please advise:
   a. Total revenues derived from supplemental staffing services: $_____
   b. Percentage of total revenues by location of staffing services (total must equal 100%)

Adult day care facilities	%	Nursing home/Assisted or Independent Living facilities	%
Clinics	%		
Doctors offices	%	Prison facilities	%
Hospices	%	Schools	%
Hospitals	%	Other (specify):_____	%
Laboratories	%	**Total:**	%

2. If Supplemental Staffing is provided to Hospitals, please specify percent of total revenues by specialized service (total must equal 100%)

Coronary care unit	%	Obstetrical	%
Emergency department	%	Pediatric	%
Intensive care unit	%	Psychiatric	%
Medical/ Surgical unit	%	All other units (specify):_____	%
Neonatal	%	**Total:**	%

3. Do contractual agreements to provide temporary or supplemental staffing to client facilities include the following provisions:
   a. Mutual indemnification and hold harmless agreements? ☐ Yes ☐ No
   b. Require third parties to carry liability insurance with limits of at least $1M/ $3M? ☐ Yes ☐ No
   c. Please provide a copy of the Applicant's standard contract.

SECTION IX - PHARMACY ☐ N/A

1. If Applicant owns or operates a pharmacy what are the total receipts from:
   a. Retail pharmacy $_____
   b. Closed pharmacy $_____
   c. Mail/Online Orders $_____
   d. Does the pharmacy compound medications? ☐ Yes ☐ No
   e. Does the pharmacy dispense controlled narcotics? ☐ Yes ☐ No
   f. Does the pharmacy provide medications to other organizations? ☐ Yes ☐ No
   If yes, please describe:

_____

SECTION X – CHILDCARE/ DAYCARE ☐ N/A

1. What is the total number of individuals providing childcare/ nanny care/ day care:
   Employees:_____ Independent Contractors:_____ Volunteers: _____
   Are the above individuals included in question #18 of Section 1 and the payroll figures? ☐ Yes ☐ No
2. Please provide the number of child care / nanny care / day care visits the Applicant makes in a month:
3. Does the Applicant provide transportation of children? ☐ Yes ☐ No
   If yes, how many trips and average miles per month?

_____

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SECTION XI – WARRANTY STATEMENT

NOTICE: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

☐ N/A (Please process to signature section)

Policy Effective Date:_____
Line of Business:_____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against them? ☐ Yes ☐ No
   If yes, please provide details:

2. Upon inquiry of any person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying for? ☐ Yes ☐ No
   If yes, please provide details:

FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that they/ them are an authorized representative of the Applicant and declares to the best of their knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

VIRGINIA APPLICANT: READ YOUR POLICY. THE POLICY OF INSURANCE FOR WHICH THIS APPLICATION IS BEING MADE, IF ISSUED, MAY BE CANCELLED WITHOUT CAUSE AT THE OPTION OF THE INSURER AT ANY TIME IN THE FIRST 60 DAYS DURING WHICH IT IS IN EFFECT AND AT ANY TIME THEREAFTER FOR REASONS STATED IN THE POLICY.

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE (OR STATEMENT OF CLAIM) CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). **(NOT APPLICABLE IN AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NY, OH, OK, PA, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, LA, MD, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND/OR CONFINEMENT IN PRISON (IN ALABAMA, MAYBE SUJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF).

APPLICABLE IN CALIFORNIA: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDLENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN DISTRICT OF COLUMBIA: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

APPLICABLE IN FLORIDA ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN KENTUCKY: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSONS FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

APPLICABLE IN MAINE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

Print Application Clear Application

APPLICABLE IN NEW JERSEY: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

APPLICABLE IN OHIO: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

APPLICABLE IN OKLAHOMA: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

APPLICABLE IN PENNSYLVANIA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN VERMONT: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

APPLICABLE IN NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION. THIS APPLIES TO AUTO INSURANCE.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, BOARD CHAIR, CEO OR EXECUTIVE DIRECTOR)

SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)